

Physician Assisted Suicide and the Supreme Court: Putting the Constitutional Claim to Rest

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ABSTRACT

Like the debate about many controversial questions of ethics and medical care in America, public debate about physician assisted suicide became focused on questions of constitutional law. On June 26, 1997, the United States Supreme Court unanimously rejected any constitutional right of terminally ill patients to physician assisted suicide. An analysis of the Court's reasoning reveals that its decisions resolved only a narrow constitutional question that affects relatively few people—mentally competent, terminally ill patients who wish to hasten their imminent deaths by having a physician prescribe medication that they intend to use to commit suicide. Although suicide is not a crime, states remain free to prohibit assisted suicide. One consequence of the Court's decisions may be renewed debate on state laws. A more productive result would be to address the broader public health concerns that gave rise to support for physician assisted suicide—inadequate care for the terminally ill and prevention of suicide. (*Am J Public Health* 1997;87; 2058–2062)

More than 30 000 people commit suicide each year in the United States.¹ None of them commit a crime. Their deaths are not celebrated as expressions of individual freedom, however. Suicide is a major public health problem because so many suicides are unnecessary, the result of mental illness, despair, and sometimes even coercion.² Yet the suicide "problem" that has attracted the most public attention is not that there are too many suicides but that there are too few, at least among terminally ill patients. The proposed solution has been to guarantee terminally ill patients who want to commit suicide a constitutional right to a physician's assistance in doing so.

On June 26, 1997, in *Washington v Glucksberg*³ and *Vacco v Quill*⁴, the United States Supreme Court unanimously rejected any constitutional right of terminally ill patients to physician assisted suicide and left the states free to permit or prohibit assistance in suicide. The two cases claimed different constitutional grounds for a right to physician assisted suicide. In 1996, the Ninth Circuit Court of Appeals had held that the Due Process Clause of the 14th Amendment of the federal constitution protected a fundamental right for terminally ill patients to "hasten death."⁵ Soon thereafter, the Second Circuit Court of Appeals held that the Equal Protection Clause of the 14th Amendment entitled terminally ill patients to obtain a physician's assistance in committing suicide.⁶ The Supreme Court unanimously reversed both circuit courts' decisions.^{3,4}

The Supreme Court's decisions resolved only a narrow constitutional question that affects relatively few people. If this is understood, Americans can return to the broader public health questions of how to prevent suicide and how to care for terminally ill and suffering patients.

Glucksberg and the Due Process Claim

The legal question in *Glucksberg* was whether the Due Process Clause of the 14th Amendment protected the claimed right to physician assisted suicide. The Due Process Clause forbids the states from depriving "any person of life, liberty or property, without due process of law."⁷ A group of physicians argued that Washington State deprived them of an essential aspect of their liberty because Washington criminal law provides that "a person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."⁷ (Several patients had been plaintiffs in the original lawsuit but died before the case reached the Supreme Court.) A person convicted of the crime of aiding suicide is subject to up to 5 years imprisonment and a fine of up to \$10 000.⁸

The Supreme Court defined the question before it as "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in so doing."³ All of the justices agreed that the Constitution does not protect any right to commit suicide. The fact that suicide is not a crime in any state in the country does not mean that it is a constitutionally protected right. Rather, suicide has been decriminalized because it is impossible to punish a person who has killed him or herself.

Chief Justice Rehnquist's opinion for the Court reviewed the history of laws

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against suicide and found "a consistent and almost universal tradition that has long rejected the asserted right, and continues to reject it explicitly today, even for mentally competent, terminally ill adults."³ Although suicide was once a crime in England, punishment was generally limited to forfeiture of the deceased's property and ignominious disposal of the body.⁹ The American colonies applied English law until, after they became states, they recognized that such forfeitures only punished the families of the deceased. Thus, the states abolished all penalties for suicide and attempted suicide. Even so, they retained their laws prohibiting one person from helping another to commit suicide.

The physicians had argued that the claimed right was analogous to a woman's right to decide to have an abortion, as reaffirmed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.¹⁰ But the Court saw no reason to extend *Casey* beyond abortion: "That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."³ Thus, "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause."³

Because the asserted right was not deemed to be fundamental under the methodology used for analyzing the constitutionality of state laws, Washington's law would be constitutional as long as it were rationally related to legitimate state interests.^{11,12} This test is easily met in all but the rarest case. States have many legitimate interests that they can protect if they choose, and there are many ways to protect those interests. The state need not select the best policy option; it need only show that its choice is rational.

The Court found five legitimate state interests that Washington's law served in a rational way, all of them focused on public health goals. The least persuasive was the state's interest in the integrity and ethics of the medical profession, which has never been sufficient by itself to outweigh the exercise of a constitutional right. The Court acknowledged disagreement within the profession but considered it reasonable for the state to favor those who opposed physician assistance in suicide as inconsistent with the physician's role as healer.

A second state interest was the preservation of human life. In an unfortunately phrased argument, the physicians asserted that the state has a lesser interest in pre-

serving the lives of those who are terminally ill than in preserving the lives of "those who can still contribute to society and enjoy life." Washington's law rejected this "sliding scale" approach to the value of human life, and the Court found its choice more than rational.

A third state interest was the prevention of suicide. The Court recognized that "suicide is a serious public health problem, especially among persons in otherwise vulnerable groups."³ It noted that people "who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders" and that legalizing physician assisted suicide "could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses."³

The Court was sensitive to the possibility that people could be mistreated, abandoned, or even murdered under the pretext that they had requested physician assisted suicide. It described a fourth state interest as protection of "vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, or mistakes." The Court cited studies of euthanasia in the Netherlands, where physicians who comply with the verified request of a competent person may assist that person in committing suicide without fear of prosecution. The Dutch government's own study found more than 1000 cases of euthanasia without any explicit request by the patient and another 4941 cases in which there was no explicit consent by the patient.¹³ Thus, even when the practice is carefully regulated, patients have been killed without their consent. The Court also recognized that financial pressures might induce terminally ill patients to resort to suicide to spare their families the cost of end-of-life care and could create dangerous incentives for providers to withhold services that could counteract suicidal impulses. As Arthur Caplan observed, "You don't find many poor peoples' organizations lobbying for legalization of assisted suicide."¹⁴

A final, related state interest was prevention of euthanasia. Although the physicians claimed that any right to assistance in suicide should be limited to mentally competent, terminally ill patients, the Court understood that the impact of its decision "cannot be so limited." If the Constitution protects a right to assistance in suicide, there is no constitutional principle that would limit its exercise to a small, ill-defined group of "terminally ill" people.¹⁵ Constitutional rights are generally

applicable to everyone. The physicians' justification for protecting the claimed right to assistance in suicide was that persons who are terminally ill, suffering, and near death should be able to have their physicians help them to die quickly. But suffering is not limited to those who are dying. Nor is suffering necessarily limited to physical pain. There is no reason in logic or law why people, whether mentally competent or not, should be denied the right to assistance in suicide if they believe they have suffered enough and wish to die. "Thus," the Court concluded, "it turns out that what is couched as a limited right to 'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain."³

Not mentioned explicitly was the fact that there is no reason why any right to assistance in suicide should be limited to assistance by physicians. Anyone can assist someone else in committing suicide. The subject is not taught in medical school. Nonphysicians (including Jack Kevorkian, whose medical license has been revoked) who help another person commit suicide are not charged with practicing medicine without a license; they are charged with assisting suicide. Most successful suicides result from methods that involve no medical skill. For example, gunshots are the most common method among the elderly.¹⁶ Indeed, thousands of people commit suicide every year with no help from anyone. Thus, there is no basis for limiting a constitutional right to assistance by a physician or assistance by prescribing drugs. Logically, the right would have to encompass all individuals and all reasonably effective methods.

Vacco and the Equal Protection Claim

Vacco v. Quill presented a different constitutional argument in favor of physician assistance in suicide.⁴ The Second Circuit Court of Appeals found that, although there was no constitutional right to physician assisted suicide, the Equal Protection Clause of the 14th Amendment barred New York state from prohibiting it.⁶ The Equal Protection Clause does not grant substantive rights to anything. A basic principle of justice, it requires that the law treat like things alike.^{10,11} But it does not preclude the state from treating different things differently in instances in which a legitimate state interest justifies different treatment.

New York's law provided that a person was guilty of manslaughter if he or she "intentionally cause[d] or aid[ed] another person to commit suicide"¹⁷ and guilty of the lesser felony of "promoting a suicide attempt" if he or she "intentionally cause[d] or aid[ed] another person to attempt suicide."¹⁸ The plaintiffs argued that there was no difference between refusing lifesaving medical treatment, which New York law permits, and committing suicide, and that a physician who assists a person in committing suicide is doing "essentially the same thing" as withdrawing lifesaving medical care.

This is a remarkable argument, and a dangerous one to have put forth. It was predictable that the Supreme Court would rule, as it did, that there is no constitutional right to assistance in suicide. If, in so doing, the Supreme Court had agreed (as it did not) that there was no difference between refusing treatment and committing suicide, it could have struck down the well-established right of all patients to refuse medical treatment or restricted it to terminally ill patients.

Instead, the Supreme Court recognized the difference between the two and strongly hinted that the right to refuse treatment deserved constitutional protection, even if assistance in suicide did not. The right to refuse treatment has deep roots based on fundamental common law principles of bodily integrity, freedom from unwanted touching, autonomy, and self-determination.¹⁹ No one is permitted to violate the bodily integrity of anyone else, and, for this reason, no physician may treat a patient without that patient's consent.²⁰ The right to refuse treatment is not limited to people with terminal illnesses.²¹ Any person can refuse any treatment for any reason. This includes people who are not mentally competent; their preferences can be expressed by a surrogate decision maker or advance directive.²²

The Supreme Court had recognized this principle in *Cruzan v Director, Missouri Department of Health*.²³ Although it did not then go as far as declaring a constitutional right to refuse treatment, it did state that "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions,"¹³ and it affirmed the importance of the principle in *Glucksberg*.

State courts and legislatures have never equated refusing treatment with committing suicide.²⁴ One difference is the cause of death in the two cases. When

a person refuses lifesaving treatment, the cause of death is the underlying disease. Life-sustaining interventions such as ventilators and feeding tubes can only postpone death by substituting for bodily functions that no longer operate spontaneously. Removal of the intervention cannot itself cause death. The patient dies because her or his underlying medical condition makes it impossible for life to continue. In contrast, if a physician were to inject a lethal dose of morphine into a patient, then morphine would be the cause of death, independent of the patient's disease.

The more important difference, however, lies in the actor's intent, as the Supreme Court recognized. There are many reasons for refusing treatment: skepticism about the treatment's effectiveness, fear or dislike of the intrusion, or religious beliefs, for example. People who refuse lifesaving or life-sustaining treatment recognize that they may die without the treatment, but that does not mean that they want to die or intend to commit suicide.²⁵ For example, in New York, Brother Fox, a member of a Catholic religious order, told his friend, Brother Eichner, that if anything went wrong during his impending surgery, he would refuse all life-sustaining treatment because he did not want to end up like Karen Ann Quinlan. The New York court upheld Brother Fox's right to refuse treatment as entirely different from suicide.²⁶ Indeed, Brother Fox would have been horrified at the idea that anyone believed that his choice amounted to suicide, which is a mortal sin according to Catholic doctrine.

The difference between intending an outcome and accepting the risk of an unintended consequence is well accepted in medical care that does not involve life-sustaining interventions. If a patient who undergoes surgery to obtain relief from back pain dies as a result of foreseeable anesthesia complications, it cannot be concluded that the patient intended to die or that the physician intended to help the patient commit suicide. Death was a foreseeable risk but an unintended consequence. The occurrence of an undesired consequence does not retroactively change the patient's or the physician's intentions.

The ethical and theological principle of double effect makes the same distinction primarily on the basis of intent. An act intended to achieve a good result can simultaneously, but indirectly, have additional undesired and unintended consequences. Actions that can result in death (or other moral harms) are morally per-

missible if the actor intends only a good effect (such as relief of pain); the action taken is itself good (such as providing pain medication) or, at least, not bad; the good effect outweighs the bad effect (relief of pain outweighs the risk of death); and the bad effect is not the means of achieving the good effect (death is not the method by which pain is relieved).²⁷

There may be patients who refuse treatment because they wish to commit suicide, and there may also be physicians who withdraw treatment because they wish to kill their patients. But the question before the Supreme Court was whether it was rational for a state to presume that a person who refuses treatment does not intend to die and that a physician who withdraws lifesaving treatment does not intend to kill the patient. There is no question that these presumptions are rational. Indeed, it would be irrational to presume the opposite: that everyone who refuses treatment intends to commit suicide. With that presumption, every patient who refuses lifesaving treatment (no matter the reason) would be deemed to be committing suicide, and every physician who complies—as he or she must—with the patient's request to remove lifesaving treatment would be considered to assist the patient in committing suicide. The vast majority of deaths occur in hospitals after a decision is made not to use life-sustaining treatment, from ventilators to cardiopulmonary resuscitation. If all such deaths were considered to be assisted suicides, it would effectively abrogate the right to refuse treatment, subject most deaths to criminal investigation, and throw into disarray other legal consequences of death such as life insurance benefits and religious burial. It would also render vital statistics on causes of death meaningless.

The Supreme Court concluded: "We think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational."⁴

The Insignificance of Not Having a Constitutional Right

The fatal flaw in the case for physician assisted suicide was the impossibility of defining the right in a principled manner consistent with constitutional law. The Ninth Circuit had had difficulty describing

exactly what the right entailed, calling it variously a "right to hasten one's death" and "a liberty interest in determining the time and manner of one's death."⁴ The plaintiffs called it a "liberty interest to choose how to die" and a right to "control one's final days." Most people would probably choose to die in their sleep after decades of perfect health. But people cannot determine the time or manner of their own death unless they commit suicide, and no law prevents anyone from attempting or committing suicide in this country. Thus, no law prevented the exercise of this vague "right" to hasten or determine the time and manner of one's death.

What was at issue in these cases, therefore, was not the ability to determine the time and manner of one's death, or even the ability to hasten death, but the ability to either obtain prescription drugs solely for the purpose of committing suicide or engage a physician to inject a lethal dose of drugs that would cause death. The only laws that prevent such actions are the laws against prescribing drugs without a legitimate medical purpose for a patient. Thus, the plaintiffs could have asked Congress or state legislatures to change those laws.

Why did the plaintiffs seek a vague constitutional right instead of a precise exception to the laws that actually stood in their way? Perhaps because they believed, as they argued in *Vacco*, that any action that contributes to the death of a patient must have been intended to cause death. But physicians routinely write prescriptions for medications that, if taken by a patient in too large a dose, could result in the patient's death, and those physicians certainly are not guilty of assisting suicide.

The crime of assisting suicide requires much more than writing a prescription. It requires intent to cause a person's death and providing the means by which that person actually kills her- or himself or immediate help performing the act of suicide.^{28,29} Laws prohibiting assistance in suicide would apply to physicians who prescribe drugs for their patients only if the drugs are not medically indicated, the physician intends that the patient use them only to commit suicide, and the patient actually does use them to kill her- or himself.

There is no reason to believe that it is a crime for a physician to prescribe a medically indicated drug for a patient's medical condition, especially when the physician does not specifically intend that the patient commit suicide. First, the physician has no control over whether the patient even fills the prescription or ever

actually takes the drugs and, if so, whether they are taken for their medical purpose or to commit suicide. The patient controls these acts, and they can occur over a long period of time. Second, the physician has no control over the patient's mental state. A patient may or may not reveal to the physician an intention to use drugs to commit suicide, and, whatever the patient's original intention, he or she may have a change of heart later.

Physicians who fear laws against assisted suicide may be concerned about ambiguity in their own intentions. For example, if they recognize that increasing doses of pain relief are likely to hasten a patient's death, does that mean that they intend to slowly kill the patient? It seems improbable. If a physician intends to kill the patient to relieve suffering, he or she should be willing to do so all at once, instead of titrating doses according to the level of pain. Whatever the philosophical debate over such a question, criminal law cannot assign guilt on that basis.

No physician in the United States has ever been indicted, much less convicted, of the crime of assisted suicide for writing a prescription for a terminally ill person.³⁰ In a *New England Journal of Medicine* article, one of the named plaintiffs in *Vacco*, Timothy Quill, MD, "confessed" to the act of prescribing drugs for insomnia for a long-time terminally ill patient who later killed herself with the drugs.³¹ Yet, even with this evidence, a grand jury refused to indict Quill, and an investigation by the New York State Board for Professional Medical Conduct concluded that Quill had acted properly, as indeed he had. The pills were prescribed for a legitimate medical indication and, although Quill knew that his patient might eventually take them to commit suicide, he did not want her to do so, nor did he participate in any way in her death. As one prosecutor was reported to say, "You almost never have the evidence to prosecute."³² It is impossible to prove intent to kill when a physician prescribes medication for which the patient has a legitimate medical need. It is not even worth initiating prosecution, because, as another prosecutor noted, "A jury will not find somebody guilty for something they believe in their hearts was a blessing, no matter what a legal statute says."⁹

The plaintiffs in *Glucksberg* and *Vacco* sought a constitutional right for a narrow class of people: those who were expected to die within a few days or weeks, who were suffering because of great pain that could not be medically controlled, and

who were mentally competent and capable of making a decision to commit suicide. This seems a tiny fraction of the people who might want help in committing suicide. If so, the lack of constitutional protection will affect only a handful of people.

Conclusion

The Supreme Court's decisions leave the law where it stood before the cases were brought. There is no constitutional right to commit suicide, but suicide remains lawful in all of the states because it cannot (and, in this author's opinion, should not) be punished. The states remain free to discourage suicide, to study its causes and effects, and to develop methods to prevent people from killing themselves because of mental illness or coercion. The states are also free to prohibit anyone, including physicians, from assisting another person in committing suicide. But prescribing and administering drugs with the intention of providing pain relief to patients is not assisted suicide; it is good medical practice. Finally, the states remain free to enact legislation, like Oregon's statute,³³ permitting assisted suicide. But efforts to enact such legislation run the risk of distracting attention from more widespread public health problems.

Physician assisted suicide cases have attracted far more public attention than the constitutional issue alone has warranted, largely because of concern for the way people die in the United States. Support for physician assisted suicide reflects widespread fear of dying a painful and prolonged death based on the inadequacy of palliative care at the end of life.²⁵ Justices O'Connor and Breyer echoed that concern in their brief concurring opinions.^{3,4} They suggested that patients should be able to obtain sufficient pain medication and palliative care to avoid suffering at the end of life. Both justices noted, however, that nothing in the state laws prevents physicians from giving patients adequate pain relief, and therefore the states did not block patients from obtaining relief from suffering. The law offers no excuse for letting a patient suffer.

The debate over physician assisted suicide largely preempted consideration of the public health problems of suicide among those who are not terminally ill and inadequate care for terminally ill patients who want to live. Now that the Supreme Court has ended the constitutional debate, it is time to address the nonlegal problems. One is how best to prevent unnecessary

suicides, the ninth leading cause of death in the United States. Another is how best to care for patients who suffer and patients who are dying. In the SUPPORT study, families of hospitalized patients reported that many of their loved ones spent their last 3 days of life in unnecessary pain, subjected to unwanted procedures, or "alone and isolated."^{34,35} The Institute of Medicine, among other groups, has recommended the development of more humane methods of caring for the dying, including better education and research in the specialized area of palliative care.³⁶ One means of suicide prevention is good palliative care, and all patients should have access to that care. Instead of a right to physician assisted suicide, Americans deserve a right to good health care, and not just at the end of life. □

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